REPORT OF RECOMMENDATIONS AND FINDINGS

By the Optometrists'
Technical Review Committee

To the Nebraska State Board of Health, the
Director of the Division of Public Health, Department of Health and Human
Services, and the Members of the Health and Human
Services Committee of the Legislature

October 21, 2013

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

The Optometrists' Technical Review Committee Members

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Associate Professor of Physical Therapy, Creighton University

Stephen Peters **(Omaha)**
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Jeffrey Howorth **(Omaha)**
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Meetings Held

Orientation and Initial Discussion: May 10, 2013
Discussion two: June 7, 2013
Discussion three: June 28, 2013
Discussion four: July 19, 2013
Preliminary Recommendations: August 9, 2013
Public Hearing: September 6, 2013
Final Recommendations: October 4, 2013
Teleconference to Approve Report: October 21, 2013

Part Two: Summary of Committee Recommendations

The committee members recommended against approval of the applicants' proposal for a change in scope of practice. A more detailed description of this recommendation can be found on pages 34-38 in this report.

Ancillary recommendations:

1) Dr. Dering-Anderson moved and Mr. Howorth seconded that a special committee be created consisting of physicians, pharmacists, and optometrists that would be granted authority to create a formulary for the purpose of defining which pharmaceutical agents optometrists would be allowed to use.

2) Dr. Sandstrom moved and Dr. Dering-Anderson seconded that a standard be defined for the utilization of surgical procedures by optometrists, and that this standard would require that optometrists who want to provide such services complete an accredited surgical residency program, or equivalent program, that would provide practical, hands-on training for optometrists on live patients.

3) Dr. Sandstrom moved and Mr. Peters seconded that an integrated approach be developed among eye care professionals pertinent to the utilization of immunosuppressants in which optometrists would be required to work with ophthalmologists to co-manage the use of such drugs when they are treating the eye care needs of patients who have either complex eye diseases, or who have other complex health conditions that complicate their eye care treatments.

Part Three: Summary of the Optometrists' proposal

The original proposal sought to make the following changes to optometry scope of practice:

1. **Removing specific restrictions on prescribing oral steroids, oral anti-glaucoma medications and oral immunosuppressive medications**

Oral steroids are not typically used for chronic therapy in eye care. However, for short-term use, they are safe and extremely effective. There are inflammatory conditions of the eye for which topical steroids and oral non-steroidal anti-inflammatory medications are not potent enough. The following conditions are much more effectively treated with short term oral steroids of five to seven days duration:

a) Acute periocular inflammatory dermatitis, which is inflammation of the eyelids, and is typically due to allergies,
b) Idiopathic orbital inflammation, which is inflammation of the eye socket tissue surrounding the eye, and,
c) Scleritis, which is deep inflammation of the white part of the eye.

Currently, Doctors of Optometry prescribe topical immunosuppressive medications to control chronic ocular inflammatory conditions that tend to be more superficial. Oral immunosuppressive medications also have their place in the control of chronic ocular inflammation when that condition is not responsive to topical treatments.

Oral anti-glaucoma agents are typically not used in the treatment of chronic glaucoma. When they are used, they are not prescribed for long-term therapy, but they can be very beneficial to patients who need a rapid reduction of the pressure in their eye. The most common use for this would be in acute angle closure glaucoma, which has a potential to leave a patient with irreversible vision loss if not treated promptly. Reducing the pressure inside the eye with anti-glaucoma medications is needed in order to minimize visual damage.

2. **Allowing the injection of medication for the treatment of anaphylaxis, and the injection of pharmaceutical agents into the eyelid for the treatment of cysts, or infected or inflamed glands of the eyelid**

Anaphylaxis is a rare, sudden, severe allergic reaction that can lead to death. It can be triggered by foods, environmental agents, or certain drugs. Someone who is at risk for this type of reaction would ideally carry a prescription device called an EpiPen. The EpiPen contains epinephrine which, in the case of an attack, can be self-injected by a needle into the person's thigh. If the person is too weak and unable to do their own injection, any lay person, without any formal training, can do this for them. However, under the current law, even though a patient in the optometrist's waiting room could give the injection, the optometrist cannot.

The proposal would also allow the injection of pharmaceuticals into the eyelid for treatment of cysts and infected or inflamed glands. In the continuum of care for the treatment of these conditions, it can be beneficial to inject medications into the gland. In many cases, an injection

into the gland allows for treatment and resolution of the condition without the need for removal of the cyst**.**

3. **Removing the restriction on minor surgical procedures to allow the treatment of cysts, or infected or inflamed glands of the eyelid**

The proposed change in scope of practice would authorize simple, in-office procedures that would treat various types of cysts or styes on the eyelid. These cysts or styes are fairly common when glands become infected and the procedures that would be allowed by this proposal would be for cases where other options, including simple application of pressure or injections into the infected gland, are not sufficient. The procedures involve a minute incision in the back of the eyelid, where it is not visible, so no stitches are needed. The procedures would be done in the optometrist's office and would involve use of localized anesthetic, similar to what dentists use, so the patient doesn't feel the incision. Therapeutic eye drops or oral antibiotics, which optometrists already prescribe, would be used, as needed, following the procedure. Many times, the procedure just involves release of material in the gland, not removal of tissue. But, although these cysts are typically benign, any removed tissue would be sent to a laboratory.
Since 1986, optometrists have been authorized to treat eyelid conditions with topical and oral medications. They have also been authorized to treat infected or inflamed glands through expression. The proposed new authority would allow a small incision in order to treat conditions that don't respond to pressure or medications.

The original proposal was amended to include the following:

AMENDMENT 1

Optometrists should be held to the same standard of care as a physician relative to the proposed new authority.

The following language would be intended for inclusion in Section 38-2605 of Nebraska statutes defining the practice of optometry:
"With respect to the practice of optometry as defined in this section, a licensed optometrist shall provide a standard of care to patients comparable to that provided by a physician licensed in this state to practice medicine and surgery."

AMENDMENT 2

After initial implementation of new statutory authority relative to this proposal, members of the Board of Optometry must themselves be certified at the highest level of practice authority in order for the Board to appropriately oversee and monitor competence of other licenses.

AMENDMENT 3

All licensees—existing and future—would be required to complete education and clinical training prescribed by the Board of Optometry and described in this application. The Board would then be charged with assessing the education provided by each optometry school and if graduates from that school could not show evidence of having completed specific education and training required by Nebraska, they would need to complete such education and training before being granted a Nebraska license.

AMENDMENT 4

The Board of Optometry would be directed to adopt competency standards comparable to optometric training courses required by the State Board of Optometry in Oklahoma in determining acceptable education and training for Nebraska optometrists relative to the new authority described in this proposal. Regardless of which accredited college of optometry provided training for Nebraska licensees, standardized content and outcomes assessment would be required.

AMENDMENT 5

In place of language describing requested authority for "procedures to allow treatment of cysts or infected or inflamed glands of the eyelid," a more specific description of this requested authority is substituted as follows:

"Procedures to allow treatment of chalazions, hordeolums, sweat gland cysts, and oil gland cysts of the eyelid by lancing, small incision, and curettage."

AMENDMENT 6

Faculty used by an accredited College of Optometry to provide the education and training for the certification process should include a pharmacist, primary care physician, and an ophthalmologist to teach material and procedures within their respective disciplines. In addition, the course syllabus would include education from each of these health care providers on issues of consultation and collaboration in the delivery of quality eye and vision care.

Part Four: Discussion on the Issues of the Review

1) How well does the current practice situation meet the needs of Nebraskans?

1 A) Committee discussion and issue definition:

The committee members were informed that access to care is a major issue in this review, and that there are two subcategories within access to care, and these are:

One subcategory is access to care in a total sense. The other subcategory is delay in getting access to care. The latter would include emergent care issues, for example, in which timeliness is the issue. The former pertains to the ability to get care at all. Committee discussion clarified that the issues of this review seem to focus around the second of these two subcategories, with the primary concern being timely access for persons living in medically underserved areas of Nebraska. (**Minutes of the Second Meeting, held June 7, 2013)**

What is the principal difference between optometrists and ophthalmologists?

The applicants responded that the role of optometry is to provide primary care, while the role of ophthalmology is to provide secondary care. Physicians responded that the principal difference is that ophthalmologists possess a vastly greater amount of medical knowledge and experience than do optometrists. (**Minutes of the First Meeting, held on May 10, 2013)**

What role do family practice physicians play in the provision of eye care in Nebraska? How do their abilities compare to those of optometrists in the provision of eye care?

Ophthalmologists stated that the overwhelming majority of Nebraskans already have access to high quality eye care. Additionally, emergency room physicians are available to provide treatment for emergent eye care conditions, and general and family practice physicians are capable of providing eye care if an ophthalmologist is not available. **("Updated version of the 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Care Physicians and Surgeons)**

Optometrists stated that one area of concern with the current situation is the shortage of primary care physicians as compared to the availability of optometry practitioners in our state. The applicants stated that the number of physicians is declining in Nebraska, for example. **("Documentation of Physician Shortages;" submitted by the**

Nebraska Optometric Association; and The Applicant's Proposal, Exhibit H)

Ophthalmologists responded to concerns about physician accessibility to patients in underserved areas by providing information on the availability of ophthalmology clinics and satellite clinics in Nebraska. According to them, this information shows that the majority of Nebraskans live within a thirty mile radius of an ophthalmology clinic. **("2013 County Data"; and "Ophthalmology Coverage of Nebraska Counties" submitted by the Nebraska Academy of Eye Care Physicians and Surgeons)**

Optometrists stated that family practice physicians seldom deal with eye care problems, and that they typically refer these cases to other practitioners. According to the optometrists, that is one reason why optometrists, rather than family practice physicians, should be the practitioners who take care of eye care emergencies if an ophthalmologist is not available. (**Minutes of the First Meeting**, **held on May 10, 2013)**

How well does the current situation work vis-à-vis indigent care?

Comment was made by a physician that most indigent eye care occurs in the context of the emergency room. The questioner responded that the emergency room should not be the only choice low income patients have to receive eye care services. (**Minutes of the Second Meeting, held on June 7, 2013)**

How well does the current situation work vis-à-vis access to treatment of such maladies as cysts and chalazions, for example?

Comment was made that the perspective of the consumer needs to be kept in mind, adding that the maps that supposedly show that consumers have good access to eye care services now do not adequately reveal the realities of life in rural Nebraska. Travel and access issues are major concerns for rural Nebraskans for health care services, including eye care services. The maps cannot show how distance impacts poor and elderly patients, for example. (**Minutes of the Fourth Meeting, held on July 19, 2013)**

One ophthalmologist commented that such problems as cysts are seldom urgent concerns, and that, in any case, surgery is used only as a last resort. The standard of care is to use hot compresses and then drain the cyst. Some committee members took issue with this statement by commenting that these matters might not seem urgent to some health care practitioners, but they might be urgent for some patients. The patient's concerns need to be considered, first and foremost. (**Minutes of the Fourth Meeting, held on July 19, 2013)**

What would happen to eye care services in Nebraska if the proposal does not pass?

The applicants responded that one consequence would be that current delays in getting access to care and the high cost of eye care services would continue. Delay in getting care can result in loss of vision, especially in emergency situations such as angle closure glaucoma, for example. **("Responses to the Three Sets of Questions," submitted by the Nebraska Optometric Association; and, "Key Points for Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

1 B) Applicant information and comments on the current situation:

Optometrists commented on access to care issues in eye care services in Nebraska as follows:

An applicant spokesperson stated that the number of ophthalmology practitioners has declined in Nebraska, while the number of optometric practitioners has increased, indicating that the public would be better served by passing the proposal than by not passing it. (**Minutes of the Second Meeting, held on June 7, 2013)** The applicants informed the committee members that they have provided a map documenting access to care issues in Nebraska. This map shows that there are 341 optometrists in Nebraska practicing in 61 counties. **(The Applicants' Proposal, Exhibit H)**

The optometrists commented that the arguments by physicians that family practice physicians are able to treat eye diseases, and that therefore the proposal is not needed, overlooks the fact that family practice physicians would not likely be equipped to treat eye diseases, and that they are not interested in dealing with such problems. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Jonna Kohle, O.D.)**

Optometrists stated that patients in Nebraska are not able to receive optometric care at the same level as patients in states that allow optometrists to use oral steroids and oral glaucoma agents, for example. **("Key Points for Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association)** This situation means that there is a risk that Nebraska optometrists might not be able to provide standard of care treatment for certain eye care conditions, given that new pharmaceuticals are continually entering the market. **("Key Points for Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association)**

Current inability of patients to receive care for the treatment of cysts and eyelid inflammations from optometrists can be a hardship for them in terms of time and cost. This is especially true of patients living in underserved areas of our state. Delays in the treatment of inflammations or infections of the eyelid are not in the best interests of the public. Some patients have to wait weeks to be seen by an ophthalmologist. **("Key Points for Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association)**

Optometrists commented on the effectiveness of ophthalmology outreach clinics in addressing access to eye care services in Nebraska as follows:

One optometrist commented that instead of arguing about the location of satellite offices the question of access to eye care is better answered by looking at where health care professionals actually live and provide services. He went on to state that there are only twelve communities in Nebraska that have full time ophthalmologists compared to over fifty communities that have full time optometrists. He stated that, given these facts, there can be no doubt that the proposal would increase access to eye care in Nebraska. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Robert Vandervort, O.D.)**

Optometrists commented that part of the access problem is that ophthalmologists don't cover emergency calls. Additionally, so much of the medical outreach effort focuses on such things as cataract removal. Ophthalmologists have little time for minor surgical procedures. Also, there are fewer ophthalmology clinics than optometry offices in Nebraska. **(The Applicants' Proposal, Exhibit H; the Minutes of the First Meeting, held on May 10, 2013, and the Minutes of the Second Meeting, held on June 7, 2013)**

One optometrist commented that not all ophthalmology outreach services provide the full scope of services. Some provide only certain types of services on certain days in certain locations. Some of these outreach services are full time, while others are not, and some are available only once or twice a month. Such part time access to eye care is not the same as local, timely access to the right type of eye care for each patient. This optometrist went on to state that in North Central Nebraska, for example, an ophthalmologist flies in from Arizona one day a month. The waiting list to see him is approximately three months. This ophthalmologist is primarily interested in performing cataract surgeries. Having a cataract surgeon available for one day a month does very little to give local residents access to eye care services pertinent to the conditions addressed in the optometry proposal. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Jonna Kohle, O.D.)**

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1 C) Opponent Information and comments on the current situation:

Comments from ophthalmologists were as follows:

Ophthalmologists commented that ophthalmology outreach clinics make it possible for all Nebraskans to have access to high quality eye care services. They provided information on the availability of ophthalmological clinics and satellite clinics in Nebraska**. ("2013 County Data"; and** "**Ophthalmology Coverage of Nebraska Counties," submitted by the Nebraska Academy of Eye Physicians and Surgeons)** Ophthalmologists stated that 99.5 percent of Nebraskans live within thirty miles of either an ophthalmology clinic or a satellite clinic, and that this indicates that there is no significant access issue regarding eye care services in Nebraska, and therefore there is no need for the proposal. **("Updated version of the 407 Optometry Technical Review Statutory Criteria Responses"; "2013 County Data"; and "Ophthalmology Coverage of Nebraska Counties," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

Ophthalmologists stated that access to high quality eye care is assured by a continuum of services including those of primary care physicians of which there are 746 in Nebraska. These practitioners are able to provide eye care services, and are able to provide emergency eye care services, as well. Additionally, emergency room physicians are available to provide treatment for emergent eye care conditions. **("Updated version of the 407 Optometry Technical Review Statutory Criteria Responses" submitted by the Nebraska Academy of Eye Physicians and Surgeons; and The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Richard Blatny, M.D.)**

Ophthalmologists stated that the current situation provides patients with adequate access to care for the treatment of anaphylaxis, cysts, or infected or inflamed glands of the eyelid by physicians. Injecting pharmaceutical agents into the eyelid or performing minor surgical procedures on eyelids as requested by the applicant group are advanced procedures that need to be limited to physicians. But, typically, such procedures are not necessary to treat these kinds of eyelid conditions, anyway, according to ophthalmologists. **("Updated version of the 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

One ophthalmologist commented that in his practice in Central Nebraska ophthalmologists provide a wide range of procedures including surgery in a variety of practice locations. They provide services to remote rural locations multiple times every week. He went on to state that during his

forty years of practice he has never heard a single complaint from his patients about lack of access to eye care services. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Jan V. Jensen, M.D.)**
Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

2) Access to care implications of the proposal

2 A) Committee discussion and issue definition:

What benefits might the proposal bring to the public health and welfare?

Comment was made that the proposal would benefit public health and welfare in rural areas of Nebraska by providing better access to glaucoma treatments, including the treatment of emergent glaucoma conditions. Such emergencies require speedier access to care than the current situation allows. Rural access issues are very real concerns in every aspect of health care, and eye care is no exception. Comment was made by opponents of the proposal that the potential for new safety concerns from the proposal itself cancels out any benefits that might result from improved access to optometric care. **(Minutes of the Fifth Meeting, held August 9, 2013)**

Should the scope of practice of optometry be changed to allow them to address emergent conditions?

Comment was made that the emergent conditions referred to by optometrists such as angle closure glaucoma are rare occurrences and that the law should not be changed for such rare emergencies. Some persons disagreed and commented that one emergent case is enough when people are suffering, and if optometrists could help alleviate this suffering, then we should make it easier for them to provide assistance. Comment was made that what is known as 'The Good Samaritan Law' should suffice to provide legal protection for an optometrist who engages in actions beyond their current scope of practice in order to help a person with an eye care emergency such as an angle closure glaucoma, for example. (**Minutes of the Second Meeting, held June 7, 2013)** Comment was made by one committee member that the 'The Good Samaritan Law' does not protect health professionals, only private citizens seeking to help someone when no qualified health professionals are present.

Would passing the proposal result in greater numbers of patients seeking the services of optometrists?

Comment was made that patients prefer ophthalmologists to optometrists, regardless of what the law allows optometrists to do. One applicant representative responded that his patients want him to be able to do more

than what he is currently allowed to do. **(Minutes of the Second Meeting, held June 7, 2013)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

2 B) Applicant information and comments on access to care:

Optometrists argued that their proposal would be beneficial to Nebraskans because of the following:

The current situation does not adequately address eye care needs of Nebraskans, especially in underserved areas of the state. There are too few ophthalmologists available in Nebraska to address the needs of underserved areas. **("Key Points for Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association; and "Documentation of Physician Shortage," submitted by the Nebraska Optometric Association)**

One optometrist stated that the fact that fifty Nebraska communities have optometry practitioners residing in them and that only twelve communities have ophthalmology practitioners supports the applicant groups' contention that the proposal would increase access to the eye care services described in the proposal. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Robert Vandervort, O.D.)**

Pertinent to timely access to emergency eye care in medically underserved areas, optometrists are more optimally located to provide timely access to emergency care than are ophthalmologists. **(The Applicants' Proposal, Question 2; and Exhibit H)**

The proposal would improve access to affordable, high-quality eye care in our state by reducing costs and eliminating repeat office visits. And optometry practitioners, more so than ophthalmologists, are well situated in medically underserved areas of Nebraska to make this happen. **(The Applicants' Proposal, Question 2; and Exhibit H)**

The applicants argued that family practice physicians are not a viable option for addressing access shortages in eye care services. Family practice physicians are unlikely to have all the necessary equipment to provide the full range of eye care services. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Jonna Kohle, O.D.)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

2C) Opponent Information and comments on access to care:

Ophthalmologists argued that the proposal would not be beneficial to Nebraskans because of the following:

Optometrists are not sufficiently trained in the systemic effects of complex and powerful drugs. Expanding optometric scope of practice vis-à-vis the treatment of eye disease only serves to increase risk without creating increased benefit to the public. Allowing optometrists to use injection procedures could result in delays in proper treatment or a failure to refer, causing new danger to the public. This is because optometrists are not sufficiently trained in the systemic implications of such treatment regimens to make a timely or appropriate referral. Allowing optometrists to perform surgical procedures would create new risks to public health and safety. Optometrists are not adequately trained to diagnose the systemic disease potential of such maladies as inflammation of the eye, for example. Allowing optometrists to expand their scope of practice as defined in the proposal would not benefit the public health and safety. **("Updated Version of the 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

The cost of equipment associated with the expanded scope for surgical procedures would be such that most optometrists in underserved areas would refer the procedures to practitioners in the more populous areas rather than do them themselves. The proposal is therefore unlikely to improve access to care for underserved areas. Data from states that allow the expanded scope shows that optometrists do not perform a sufficient number of injection procedures or surgical procedures to maintain competency. Increasing the public's access to these proposed new services would not be a benefit to the public, but would only increase risk of harm. Data from states that allow the expanded scope for prescriptive authority and surgical authority shows that few optometrists actually provide these services even though they are allowed to do so. **("Updated Version of the 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

Surveys show that patients tend to prefer ophthalmologists over optometrists, and that this raises questions regarding the effectiveness of the proposal in addressing access to care needs. (**"Updated Version of the 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

It would not be good public policy to make changes in the scope of practice of optometry in response to concerns about emergent conditions, such as angle closure glaucoma, for example, because such events are very uncommon. (**Minutes of the First Meeting, held on May 10, 2013)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

3) Safety implications of the proposal

3 A) Committee discussion and issue definition:

Optometrists were asked why some states have age restrictions pertinent to the application of oral medications by optometrists:

The applicants responded that these kinds of restrictions are typically agreed to in order to get a bill passed, and that typically they are not needed for health or safety reasons. (**Minutes of the Second Meeting, held June 7, 2013)**

Optometrists were asked if there are any pediatric issues the committee should be aware of in regards to the proposal under review:

The applicants responded that uveitis can be a concern as well as rheumatoid arthritis. They added that optometrists routinely consult with pediatricians and pharmacists regarding the application of oral medications. (**Minutes of the Second Meeting, held June 7, 2013)**

The applicants responded that age restrictions on optometric practice are not necessary and that they are held to the same standard of care as are physicians. Applicants added that attempting to restrict care for particular age groups as regards specific medications creates great complexity in the regulation of their profession and inevitably leads to additional legislative initiatives as changes occur in the medications available to treat eye diseases. (**Minutes of the Second Meeting, held June 7, 2013)**

Optometrists were asked if they would consider a co-management requirement for the application of oral medications, and if this could be made a requirement:

The idea of 'co-management' was discussed. Under this idea optometrists and ophthalmologists would, under certain circumstances, co-manage the eye care of patients who have complex diagnoses, or who are already taking powerful medications from other health professionals to treat unrelated illnesses. One committee member expressed disappointment that the idea of co-management was not included in the applicants' proposal as a possible answer to the current scope of practice conflict over eye care services. (**Minutes of the Second Meeting, held June 7, 2013)**

The applicants responded that the extent to which co-management is a viable option depends a great deal on how the term is defined. If the term is defined as requiring every change in treatment to be checked or approved by another professional, then optometrists would not want this approach to be implemented. The applicants stated that they would prefer consultation as the approach to use

in fostering greater cooperation between different eye care professionals in delivering care. (**Minutes of the Third Meeting, held June 28, 2013)**

Concern was raised about the idea of co-management itself. The concern was that requiring co-management could result in optometry no longer being an independent profession. One committee member also commented that co-management has been shown to delay care by as much as thirty-six hours. Additionally, powerful drugs such as Diamox create complications, regardless of who the prescriber is, and there is no clear benefit to co-management in the administration of such drugs. (**Minutes of the Second Meeting, held June 7, 2013)**

Optometrists were asked if there is a single standard of care for both optometrists and ophthalmologists, and whether this is reflected in statute:

Optometrists responded that they are held to the same standard of care as physicians. (**Minutes of the Third Meeting, held June 28, 2013)** The proposal was amended to clarify this matter by proposing that the following new wording be added to Section 38-2605 of Nebraska Statutes: "With respect to the practice of optometry as defined in this section, a licensed optometrist shall provide a standard of care to patients comparable to that provided by a physician licensed in this state to practice medicine and surgery." **(Amendment 1, NOA Amendments to the Optometry Application Accepted by the Optometry Technical Review Committee, August 9, 2013)**

Optometrists were asked what impact the proposal would have on those optometrists who are not qualified to practice at the level specified by the proposal.

The applicants responded that there are a small number of optometrists who would not meet the standards defined in the proposal. These practitioners have been prohibited by the Board of Optometry from prescribing oral medications with the penalty being loss of their license if they violate this restriction. (**Minutes of the Second Meeting, held June 7, 2013)**

Optometrists were asked whether their proposed prescriptive authority for oral steroids and immunosuppressants would create a new danger to the public health and welfare of the public.

Comment was made that oral steroids have complex effects, but that they are effective in treating ocular conditions. The applicants were asked how an optometrist would treat the eye conditions of patients with systemic diseases. The applicants responded that optometrists would treat the eye condition, while the patient's physician would manage the disease. An ophthalmologist cautioned that ocular symptoms can precede full disease manifestation and might not be recognized by a non-physician. **(Minutes of the Third Meeting, held on June 28, 2013)**

The applicants were asked whether adding more scope elements to their practice might increase the incidences of harm. The applicants responded that if that

were the case evidence from other states that already have the expanded scope would show that, and there is no such evidence. **(Minutes of the Second Meeting, held on June 7, 2013)**

Comment was made that there is no evidence to indicate that current optometry education adequately prepares optometrists to completely understanding the effects of oral steroids and immunosuppressants. An applicant representative disagreed, stating that optometrists already possess this knowledge. **(Minutes of the Third Meeting, held on June 28, 2013)**

Comment was made that optometrists have at least as much training in administering the kinds of drugs under discussion as do nurse practitioners, physician assistants, and primary care physicians, for example. The question was asked when optometrists encounter patients who need immuno-suppressants or oral steroids, will they try to treat the patient themselves, or will they refer the patient to an ophthalmologist? Comment was made that optometrists can, and already do, prescribe drugs that their current scope of practice allows them to prescribe. **(Minutes of the Third Meeting, held on June 28, 2013)**

The committee members were reminded that optometrists have been allowed to prescribe some oral medications and some topical steroids in Nebraska since 1993 without any evidence of harm to the public. The question was raised as to whether the proposed expanded scope of practice would constitute such a drastic change in policy compared to what already exists. Comment was made that there is no evidence of additional harm to the public from states that already allow this expanded scope of practice. **(Minutes of the Fifth Meeting, held on August 9, 2013)**

The applicants were asked if optometrists have sufficient staff support to provide the proposed scope of practice. The applicants responded that they do have sufficient staff support for the proposed scope changes. **(Minutes of the First Meeting, held on May 10, 2013)**

Optometrists were asked whether their proposed administration of injectable medications would create a significant new danger to the public health and welfare of the public.

Comment was made that the use of injectable medications is new to optometry and that they have little education or experience to fall back on to support the use of this modality. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

The observation was made that if delivering medication via injection is unsafe for non-ophthalmologists, then the committee should recommend that general practice physicians, nurse practitioners, and physicians' assistants also not be allowed to provide this function, since they are no more qualified to perform it than are optometrists. **(Minutes of the Second Meeting, held on June 7, 2013)**

Concern was expressed about the ability of optometrists to safely procure and store injectable medications. Given that there are shortages of some of these

drugs, it will be important to have safeguards in place to ensure that they are procured in a legitimate fashion. There will be a need for specific standards for the procurement, preparation, and handling of these drugs. **(Minutes of the Third Meeting, held on June 28, 2013)**

Pertinent to their ability to safely administer injections, the applicants stated that optometrists in Oklahoma have been giving injections since the early 1990s without any indication of harm to patients. **(Minutes of the Third Meeting, held on June 28, 2013)**

Optometrists were asked whether their proposed administration of minor surgical procedures would create a significant new danger to the public health and welfare of the public.

Comment was made that there seems to be no documentation of the existence of practice guidelines for optometrists for such procedures, and there appears to be no accreditation standard for minor surgical procedures in optometry. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

Comment was made that there are no reports of harm to the public pertinent to the performance of such procedures as removing cysts and chalazions from those states that currently allow such procedures to be performed by optometrists. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

Comment was made that the amended proposal, which now states that optometrists seek only to perform "procedures to allow treatment of chalazions, hordeolums, sweat gland cysts, and oil gland cysts of the eyelid by lancing, small incision and curttage," is no longer seeking to perform minor surgery, per se. Other persons disagreed with this assertion, stating that the procedures requested in this amendment are surgical procedures. **(Minutes of the Fifth Meeting, held on August 9, 2013)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

3 B) Applicant information and comments on the safety of the proposal:

An overview of the changes in their scope of practice since the early 1980's in Nebraska presented by the applicant group:

During the early 1980's optometrists received approval to use diagnostic eye drops. During the late 1980's optometrists received approval to use topical therapeutic medications. During the early 1990's they received approval to administer some oral medications to treat some eye diseases. During the late 1990's they received approval to provide glaucoma care. **(Minutes of the First Meeting, held on May 10, 2013)**

Optometrists commented on their record of safe and effective practice as follows:

The care provided by optometrists has been under intensive scrutiny for more than thirty years, and none of this scrutiny has revealed any problems with optometric care in Nebraska. **(Minutes of the First Meeting, Held on May 10, 2013)** There has been no evidence of harm to the public stemming from the expanded scope of practice in other states that have already approved these scope elements. **(Minutes of the Second Meeting, held on June 7, 2013)** Optometrists should not be limited to a laundry list of acceptable drugs, as some ophthalmologists have argued. Such a list would constantly be changing, and would be out-of-date very quickly. Optometrists should have the ability to use these new drugs as they become available. The applicants argued that the standard of care should govern what is used to treat a given patient. Part of that standard of care is to collaborate with other healthcare providers vis-à-vis patient care. This is something optometrists have done for many years. **(Minutes of the Third Meeting, held on June 28, 2013)**

Optometrists commented on their ability to prescribe topical and oral medications as follows:

The proposal would add oral steroids and immunosuppressants to the already considerable list of oral medications optometrists are already allowed to prescribe. For example, Nebraska optometrists have been prescribing topical steroids and anti-glaucoma medications since 1993. There is no evidence of harm by optometrists regarding these services or functions in Nebraska. There is no documented evidence from other states wherein optometrists have similar authority that any harm has resulted from these services or functions. Licensed optometrists are already required to uphold the same standard of care as physicians. (**"Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria," submitted by the Nebraska Optometric Association)**

The applicants stated that optometrists are trained to treat angle closure glaucoma emergencies using drugs such as Diamox. The applicants stated that current law interferes with the ability of optometrists to use such drugs. Those with concerns about the proposal commented that angle closure glaucoma is a rare occurrence and that using drugs like Diamox risks damage to the kidneys. Such drugs require careful study of a patient's medical history. The applicants responded that they always consider a patient's medical history when evaluating a patient. **(Minutes of the Second Meeting, held on June 7, 2013)**

Optometrists commented on their ability to administer injectable medications as follows:

Injections to the eyelid require less technical skill and less risk than procedures that Nebraska optometrists are already authorized to perform. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria," submitted by the Nebraska Optometric Association)**

There is no documented evidence from other states in which injection procedures are already allowed that any new harm to public health and safety has occurred. ("**Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria," submitted by the Nebraska Optometric Association)**

Optometrists commented on their ability to perform minor surgical procedures as follows:

The minor surgical procedures being requested require less technical skill and less risk than procedures that Nebraska optometrists are already authorized to perform, such as corneal foreign body removal, for example. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria," submitted by the Nebraska Optometric Association)**

There is no documented evidence from other states that allow optometrists to perform minor surgical procedures that any harm has occurred as a result of these procedures being administered by optometrists. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria," submitted by the Nebraska Optometric Association)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

3 C) Opponent Information and comments on the safety of the proposal:

Ophthalmologists commented on the potential dangers for the public from the proposed changes as follows:

Pertinent to the proposed expansion of prescriptive authority:

Optometrists are not physicians, and optometrists do not have the same amount of experience in managing systemic medications as do physicians. Optometrists do not fully understand the systemic implications associated with their idea for expanded practice. **(Minutes of the First Meeting, held on May 10, 2013)** The broad language in the proposal authorizing optometrists to prescribe powerful oral medications raises concerns about public safety. Optometrists should define the specific drugs that they would use, the conditions they would use them for, and how they intend to use them 'off-label'. **(Minutes of the Third Meeting, held on June 28, 2013)**

The statements of optometrists regarding their ability to prescribe powerful oral medications overlook the potential new dangers that allowing them to prescribe anti-cancer drugs and similarly powerful pharmaceutical agents would create. **("Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

Systemic immunosuppressants and oral steroids are examples of the kinds of medications that require greater knowledge and training to administer safely and effectively than is possessed by optometrists. Primary care providers, as a rule, should not be prescribing immunosuppressants. Drugs such as oral prednisone and immunosuppressants should never be the first line of treatment. The risks of their use far outweigh potential benefits. Any patient requiring oral glaucoma treatment should be seeing a physician specialist, not an optometrist. **(Minutes of the First Meeting, held on May 10, 2013; and Minutes of the Third Meeting, held on June 28, 2013)** Observation was made that the basic treatment for many ocular conditions is topical steroids, which optometrists already use. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

Ophthalmologists argued that the use of medications such as Diamox by optometrists to treat such conditions as angle closure glaucoma, for example, risks damage to the kidneys. Such drugs require careful study of a patient's medical history. They went on to state that angle closure glaucoma is a rare condition, and that should not be used to justify changes in optometric scope of practice. **(Minutes of the Second Meeting, held June 7, 2013)**

An ophthalmologist from the State of Arizona commented to the committee members about an investigation of optometry services at the Palo Alto Veterans Administration Hospital in California. According to this ophthalmologist an internal review of the charts of 381 glaucoma patients that were under the care of optometrists at that facility revealed that 22 of these patients experienced progressive vision loss, while an additional 89 were found to be at risk of vision loss. He stated that the report that was issued on this matter stated that all optometrists at that facility were practicing beyond their scope by treating glaucoma without consulting with ophthalmologists, as is required, and that the optometry service did not meet the standard of care for treating glaucoma. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Daniel Briceland, M.D.)**

An ophthalmologist from the State of Oklahoma commented that improper care is being provided by some optometrists in Oklahoma. According to this testifier a child was hit in the eye and the front part of the eye was filled with blood. An optometrist prescribed an oral glaucoma medication to treat the child's eye. This medication did not work to lower pressure in the eye. To relieve the pressure the optometrist stuck a needle into the eye. This too did not work, and the child was referred to an ophthalmologist. The ophthalmologist found that the optometrist's actions had caused internal damage to the eye that required surgery. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Cynthia Bradford, M.D.)**

A family physician commented that allowing optometrists to prescribe oral steroids and immunosuppressants exposes patients who have complex health issues to significant new danger. Patients with diabetes, for example, will experience elevated blood sugar levels when their eye conditions are treated with these kinds of powerful drugs. This testifier stated that only physicians have the necessary training to manage these situations and make necessary adjustments in medications to protect the patient from harm, and that

optometrists do not possess such training. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Richard Blatny, M.D.)**

Pertinent to the allowing optometrists to administer medications by injection:

Ophthalmologists stated that they are agreeable to having optometrists use EpiPens for emergency anaphylaxis. **(Minutes of the Third Meeting, held on June 28, 2013)** However, they continue to express concerns about optometrists utilizing injections for other purposes. Optometrists lack the ability to manage the eye conditions of patients who have serious illnesses. In these cases the eye condition might be a manifestation of an underlying systemic autoimmune disease. Optometrists typically do not see a sufficient number of patients with autoimmune diseases to be able to manage their cases safely and effectively. **("Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

One physician stated that eyelids are composed of very delicate tissue, and that they swell easily even under mild trauma. Any incision or injection there must be done correctly or it can cause scarring and deformity, which is almost impossible to correct. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Richard Blatny, M.D.)**

Pertinent to the allowing optometrists to perform minor surgical procedures:

Surgical procedures should be done only by physicians. Optometrists are not able to provide surgical services safely and effectively. The maladies cited by the applicants as requiring surgical procedures such as cysts and chalazions, for example, are seldom emergent conditions, and are typically treated by non-surgical means. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

Potential harm is associated with the surgical component of the proposal because optometrists lack the ability to recognize such maladies as malignancies which can occur in cysts and infections and inflammations of the eyelid, for example. Optometrists lack the ability to manage the eye conditions of patients who have serious illnesses. In these cases the eye condition per se might be a manifestation of an underlying systemic autoimmune disease, for example. Optometrists typically do not see a sufficient number of patients with these kinds of complex conditions to be able to manage their cases safely and effectively. **("The updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)** It takes many years of experience to determine whether an eyelid lesion is benign or malignant, and optometrists lack the necessary training to be able to make such determinations. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Richard Blatny, M.D.)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

4) Education, training, and assessment of optometrists

4 A) Committee discussion and issue definition:

Is current optometry education and training sufficient to allow optometrists to prescribe oral steroids and immunosuppressants?

The applicants stated that optometrists already possess sufficient education and training for optometrists to administer oral medications safely and effectively. **(The Applicants' Proposal, Responses to Question 11, and Exhibit B)**

Pertinent to the use of oral steroids and immunosuppressants, comment was made that the use of some oral medications was added to the optometry scope of practice in Nebraska in 1993, and that the national optometric licensing examination, which Nebraska uses, added examination components pertinent to the use of oral medications that same year. **(Minutes of the Third Meeting, held on June 28, 2013)**

Ophthalmologists stated that they oppose optometrists prescribing oral steroids and immunosuppressants due to the shortcomings of their education and training in systemic disease processes and the systemic impacts of powerful oral medications. Comment was made that the current education and training of optometrists does not sufficiently cover 'full-body response' for patient safety in these circumstances. An optometric representative asserted that optometrists already have the knowledge necessary to manage systemic implications of their treatment regimens. **(Minutes of the Third Meeting, held on June 28, 2013)**

The committee members were informed that the typical amount of training received by such professionals as nurse practitioners, physician assistants, and general practice physicians in prescribing oral immunosuppressants is three contact hours. Comment was made that requiring any greater amount of training for optometrists to do the same thing seems incongruous. Comment was also made that the term 'immunosuppressants' is so broad as to have very little meaning. It is inclusive of such drugs as Tylenol and Benadryl, for example. Comment in response to these assertions was that the term in question is inclusive of very powerful drugs used to treat serious illnesses, and that such drugs should not be used by primary care providers, in any case. **(Minutes of the Fifth Meeting, held on August 9, 2013)**

Comment was made that the use of oral anti-glaucoma agents is supported by current optometric education. **(Minutes of the Third Meeting, held on June 28, 2013)**

Are optometrists adequately trained and educated to perform injections to treat anaphylaxis, cysts, and infected or inflamed glands of the eyelid?

The applicants were asked if there could be problems with the speed with which injected drugs take effect, in particular with adverse side-effects from injected drugs. The applicants responded that many topical agents actually work faster than some injected agents. **(Minutes of the Third Meeting, held on June 28, 2013)**

The observation was made that national standards for injections for optometrists were defined in 2012, and the question was asked whether the training of Nebraska optometrists meets these standards since they are so new. It was also noted that many states specifically bar optometrists from giving injections. **(Minutes of the Third Meeting, held on June 28, 2013)**

Concern was expressed about the apparent lack of documentation of optometric education, training, and testing pertinent to the administration of medications via injection. Comment was made that the applicant group needs to clarify how optometrists learn to perform injections and how competency to do these procedures is demonstrated. One committee member stated that these procedures require didactic and practical clinical training as well as standardized testing procedures and competency verification procedures, and that there is no evidence that these things are in place under current optometric education and training. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

Are optometrists adequately educated, trained and tested to perform the advanced surgical procedures defined in the proposal?

The applicants responded that such training and testing already occurs in states in which the advanced procedures in question are allowed. (**Minutes of the First Meeting, held on May 10, 2013)**

Comment was made that no documentation of training or curriculum pertinent to these procedures for optometrists can be found. Also, there appears to be no accreditation standard for minor surgical procedures in optometry. Comment was also made that no documentation regarding standardized testing for such procedures in optometry can be found. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

How effectively would optometrists be assessed on their performance of the proposed new scope elements if the proposal were to pass?

Comment was made that the Board of Optometry would do this for optometrists, and that it might be helpful to give the board direction in this matter. The effectiveness of this measurement process was questioned by some committee members given that it is not clear whether the members of the Board of Optometry would, themselves, possess the necessary education and training to perform such testing or assessment, especially during the time immediately after passage of the proposal. **(Minutes of the Fourth Meeting, held on July 19, 2013)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

4 B) Applicant information and comments on optometric education and training:

Optometrists described their education and training as follows:

Every person licensed to practice optometry in Nebraska must be a graduate of doctoral level college of optometry accredited by the Accreditation Council on Optometric Education (ACOE) and hold a Doctor of Optometry degree. Every licensed optometrist must have passed all three components of the standardized National Board of Examiners in Optometry examination (NBEO), including the portion on Treatment and Management of Ocular Disease (TMOD). **(The Applicants' Proposal, Question 10)** The NBEO examination consists of two written parts and a clinical component. This examination covers all aspects of eye care. They must also pass a written examination on current Nebraska law. They must also be certified by the Nebraska Board of Optometry. **(The Applicants' Proposal, Question 11)**

The Doctor of Optometry degree is comparable to other doctoral level disciplines such as Medicine, Dentistry, and Podiatry. After earning a bachelor's degree, optometry students must complete four years of post-graduate education in optometry for a total of eight years of study. The first two years of optometry school are focused on intensive classroom study of topics that include human anatomy, physiology, and pharmacology. This course of study is equivalent to the courses taken by medical students, and in some instances, optometry students and medical students take the same classes together. **(The Applicants' Proposal, Question 11)**

During those first two years optometry students take courses that are unique to optometry, including ocular pharmacology, ocular anatomy, ocular physiology, and ocular microbiology. The applicants commented that the profession most comparable to them in terms of length and style of training is dentistry. **(The Applicants' Proposal, Question 11)**

Clinical training begins in the second year of optometry school. The third year is approximately one-half patient care and one-half classroom study. The fourth year is focused entirely on patient care. During this fourth year students rotate through a variety of settings including multidisciplinary health care institutions such Veterans' Administration medical centers and community health centers. **(The Applicants' Proposal, Question 11)**

The applicants stated that additional educational and training provisions would be required in order to perform the new elements of the expanded scope of practice, and these are described in the proposal. **(The Applicants' Proposal, Exhibit B)**

An optometrist made the observation that what matters in the review of this proposal is not whether optometry education and training is comparable to that of ophthalmology. What matters is whether optometry education and training is sufficient for the specific new authority being requested in the proposal. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Heidi Lichtenburg, O.D.)**

An optometrist commented that the procedures being requested in the proposal are not significant departures from current optometric scope of practice. For example, optometrists already are allowed to perform procedures for corneal foreign body removal and dilation and irrigation of the lacrimal system. The technical skills used in these procedures are similar to those that would be used in the procedures being requested. Additionally, the proposed coursework for the new procedures is similar to those used to train other professions such as dentistry and podiatry for new procedures. These professions utilize lectures, lab exercises, discussion, and demonstration using models rather than live patients. Such courses are routinely accepted by licensing boards of these professions as being sufficient for learning new procedures. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Christopher Scott Wolfe, O.D.)**

Nebraska optometrists have been prescribing oral medications for two decades, and already have an extensive knowledge of pharmacology. Optometrists have been prescribing a wide range of oral and topical medications safely and effectively since 1993. Included among these medications are topical versions of oral steroids. Also included among these medications are drugs that could be defined as immunosuppressants. Optometrists already understand the risks associated with oral medications. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Chad Hudnall, O.D.)**

The proposal authorizes injections to treat cysts and for EpiPen injections. But it does not authorize all kinds of injections. Using a needle to give simple injections is a skill that many lay people easily master. There is no reason to believe that optometrists cannot also master such skills. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Chad Hudnall, O.D.)**

The proposal would not authorize optometrists to perform a wide range of surgical procedures. It would authorize only a very narrow range of procedures similar to what they have already been doing for two decades pertinent to removal of foreign substances from the surface of the eye, for example. Pertinent to these procedures, there is no evidence that medical school is the appropriate standard of education and training for optometrists to perform them. Other professions such as podiatry and dentistry, for example, perform a wide variety of similar procedures without having to go through medical school. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Chad Hudnall, O.D.)**

An optometrist from the State of Oklahoma commented on the educational and training standards for optometry in that state. He responded to concerns about optometry testing by stating that the format for competency testing in optometry

is the same as that used by dentistry, podiatry, and medicine, and that none of these professions test on any specific skill for purposes of licensure. This testifier went on to state that ACOE accredited programs utilize testing and clinical skill assessment to demonstrate the mastery of skills by optometry graduates. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of David A. Cockrell, O.D.)**

Optometrists recognize the need for independent testing of optometry graduates. For this purpose the National Board of Examiners in Optometry has a three-part examination. This examination process is designed to assess the competency of optometry graduates. All three parts of this examination must be passed before an optometry graduate is eligible to sit for the licensure examination in the State of Oklahoma. Additionally, to ensure public safety, standardized coursework has been required to augment the knowledge, education, and training of optometrists. Successful completion of this coursework is required prior to becoming eligible to sit for licensure in Oklahoma. This applies to all optometry graduates, including those from other states seeking licensure in Oklahoma. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of David A. Cockrell, O.D.)**

The Chair of the Nebraska Board of Optometry stated that this board on many occasions during the last three decades has been charged with helping develop rules and regulations pertinent to changes in the scope of practice of optometry. He went on to state that infrequent investigations of Nebraska optometrists, and the fact that there have been no complaints against optometrists associated with scope of practice issues in Nebraska, indicates that this board has done its job effectively. He added that this board has a proud history of being proactive when it comes to protection of the public and insuring the competency and professionalism of all optometrists in Nebraska. **(The Transcript of the Public Hearing, held on September 6, 2013, the testimony of Kim Baxter, O.D.)**

Optometrists commented on their training to prescribe oral medications as follows:

Optometrists stated that all graduates of accredited colleges of optometry have extensive education in pharmacology, including oral pharmaceuticals that are part of the proposed expanded scope of practice. They are all required to pass a standardized licensing examination that tests them on these medications and their risks and side-effects. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association)** Optometrists have been prescribing a wide range of oral and topical medications safely and effectively since 1993. **(The Transcript of the Public Hearing, held on September 6, 2013, the Testimony of Chad Hudnall, O.D.)**

Pertinent to the use of oral glaucoma medications by optometrists, optometrists are trained to treat angle closure emergencies using drugs such as Diamox, but that current law interferes with the ability of optometrists to use such drugs. **(Minutes of the Second Meeting, held June 7, 2013)** Optometrists always consider a patient's medical history when evaluating what drugs to use to treat their eye conditions. **(Minutes of the Fourth Meeting, held June 28, 2013)**

The optometrists informed the committee members that their proposal would require all licensed optometrists in Nebraska to complete a minimum 4-hour review course dealing specifically with oral steroids, oral glaucoma medications, and oral immunosuppressants, and pass a test upon completion of the course. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association; and The Applicants' Proposal, Exhibit B)**

Optometrists commented on their training to administer medications via injection as follows:

Optometrists are trained to provide injections, and some of the medications discussed in the proposal require administration via injection. As part of the Doctor of Optometry curriculum, optometrists are trained to recognize the symptoms of anaphylaxis and are trained to administer medications via injections to treat it. They are required to take the Injection Skills Examination portion of the 'NEBO' examination, which is part three of that examination. All three of these examination components would need to be passed prior to receiving a license in Nebraska under the terms of the proposal. **("Proponents' supporting arguments for authority to administer injections," submitted by the Nebraska Optometric Association)**

The optometrists informed the committee members that their proposal would require all licensed optometrists in Nebraska to complete additional training to provide these procedures. This training would include an 8-hour clinical injection skills course that would also include pharmacology, clinical indications, systemic side-effects, and actual injection technique, for example. This training must occur at an accredited college of optometry, and would also require passing a competency-based test upon completion of the course. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association; and The Applicants' Proposal, Exhibit B)**

Optometrists in Oklahoma have been giving injections since the early 1990s without any issues of patient harm. There are specific continuing education requirements for these kinds of procedures. However, national standards for optometric use of injections have not been formulated because they are permitted in only a few states. **(Minutes of the Third Meeting, held on June 28, 2013)**

Optometrists commented on their training to perform minor surgical procedures as follows:

Optometrists are trained to perform such minor surgical procedures as removing cysts and chalazions. Optometrists are trained to submit extracted materials to a laboratory for analysis and further diagnostic procedures. Optometrists are trained to refer patients to medical specialists for conditions that are beyond their expertise, as regards these kinds of cases. **("Proponents supporting arguments—authority for minor surgical procedures" submitted by the**

Nebraska Optometric Association; and response to question posted entitled, "Questions relating to Criteria 1-4, and 6" submitted by the Nebraska Optometric Association)

Optometrists commented that when considering the differential diagnosis that occurs with any ocular condition, including eyelid lesions, it is important to realize that optometrists are not trained in isolation from other health care providers. Ophthalmologists are among those who provide education and training for optometry students, both at the program level and the post-graduate level. Optometrists utilize the same textbooks and treatment protocols as ophthalmologists. **("Response to question posted entitled: "Questions relating to Criteria 1-4, and 6" submitted by the Nebraska Optometric Association)** Some other states have already approved these procedures for optometrists and no harm to the public has resulted. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria" submitted by the Nebraska Optometric Association)**

There is a wide variety of didactic and clinical teaching that occurs at the optometry college in Oklahoma pertinent to minor eyelid procedures, including gross anatomy working with cadavers, cellular physiology, and advanced clinical procedures including a course in minor surgical procedures. This course includes testing and candidate demonstration of techniques required for eyelid procedures. **(The Transcript of the Public Hearing, held on September 6, 2013, the Testimony of David A. Cockrell, O.D.)**

Optometrists informed the committee members that their proposal would require all licensed optometrists in Nebraska to complete additional training to perform these procedures. This additional training would consist of a 16-hour course on minor surgical procedures involving treatment of cysts or infected or inflamed glands of the eyelid. The course would include a clinical component involving performance of the procedures and would be conducted at an accredited college of optometry and proctored by a doctor licensed to perform these procedures. Passage of a competency-based test would be required upon completion of the course. **("Key Points for the Technical Review Committee: How the NOA Proposal Meets the 407 Criteria"; and The Applicants' Proposal, Exhibit B, submitted by the Nebraska Optometric Association)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

4 C) Opponent Information and comments on optometric education and training:

Ophthalmologists commented on the education and training of optometrists to provide the expanded scope of practice as follows:

Optometrists are not physicians. Optometrists do not have the same amount of education and training in managing systemic medications as do physicians. **(Minutes of the First Meeting, held on May 10, 2013; and the Minutes of the Second Meeting held on June 7, 2013)**

Systemic immunosuppressants are examples of the kinds of medications that require greater knowledge and training to administer than optometrists possess. **(Minutes of the Second Meeting, held on June 7, 2013; and the Minutes of the Third Meeting, held on June 28, 2013)**

There is no standard curriculum for the various schools of optometry. There are no standard hour or subject matter competency requirements among these schools. The degree standards show the generalities of the curricula required for accreditation by the Accreditation Council on Optometric Education. **(National Board of Examiners in Optometry: Candidate Guide, 2013; and the note submitted with the "Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

The professional education and training of each optometrist is only five years in duration, whereas the professional education and training of each ophthalmologist lasts for a minimum of ten years. Optometry education and training programs do not require internships or residency training, whereas ophthalmology education and training programs require a year of internship, followed by three years of residency training. It is also common for ophthalmologists to receive as much as two additional years of post-residency fellowship training, as well. **("Education Graph," submitted by Nebraska Academy of Eye Physicians and Surgeons)**

Optometrists' training is focused on the visual system. This training does not provide them with the medical knowledge necessary to manage patients with complex eye and medical problems. The training of optometrists focuses on the treatment of healthy eye and vision-related problems. And, although residencies are available to optometrists, only fifteen percent of optometry students choose to complete a residency. **("Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

Ophthalmologists commented on the education and training of optometrists to use of oral steroids and immunosuppressants as follows:

The proposed education and training for optometrists underestimates the necessary preparation to ensure competency to prescribe oral steroids, oral anti-glaucoma agents, and oral immune-suppressants. The proposed educational and training elements for optometrists would include completion of didactic and clinical training pertinent to examination, diagnosis, and treatment of the eye, ocular adnexa, and visual system. However, this proposed additional training does not include training in the administration of the oral medications they would be prescribing under the terms of the proposal. **("Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

Ophthalmologists commented on the education and training of optometrists to use injectable medications as follows:

Optometrists are not adequately trained to administer injections or to inject the medications they are requesting to administer. And, the post-professional education described in their proposal underestimates the necessary preparation needed to ensure competency in injection of pharmaceutical agents for the purpose of treating cysts or infected or inflamed glands of the eyelid. The proposal would provide only an additional eight hours of training for these procedures. The proposed injection skills examination of the national licensing board for optometrists requires that only two successful injections, out of four attempts, be completed during a thirty-minute examination process, and these attempts are done entirely on simulated arm and deltoid areas. (The ophthalmologists cite the **National Board of Examiners in Optometry: Candidate Guide, 2013, pages 8 and 9; and the "Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

The amount of additional training described in the applicants' proposal would not enable an optometrist to recognize whether a cyst might be malignant, for example. Such problems require the kind of education and training possessed only by physicians. Additionally, the proposal does not provide for an assessment of on-going competency by optometrists if the proposal were to pass. **(The "Updated version of The 407 Optometry Technical Review Statutory Criteria Responses," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

Ophthalmologists commented on the education and training of optometrists to perform minor surgical procedures as follows:

Nationally accredited schools of optometry do not have standard curricula to ensure proper surgical training. Optometry students do not receive 'hands-on' surgical training necessary to adequately learn to perform such procedures. **(The "Updated version of The 407 Optometry Technical Review Statutory Criteria Responses;" and "Opposition's Response to Questions–Set One," submitted by the Nebraska Academy of Eye Physicians and Surgeons)**

The proposed additional education and training described in the applicants' proposal underestimates the training necessary to ensure competency to perform such procedures. This additional training would include only sixteen hours of training in surgical procedures. This is in direct contrast to the educational training of physicians who receive years of surgical training through four years of medical school, a year of internship, and three years of residency training. Only physicians are sufficiently trained and educated to recognize malignant conditions in such maladies as cysts or infections and inflammations of the eyelid, for example. The current limitations on optometric scope of practice are intended to ensure referral and specialized care for patients with these kinds of conditions. Additionally, the proposal does not provide for an assessment of on-going competency by optometrists if the proposal were to pass. **(The "Updated version of The 407 Optometry Technical Review Statutory Criteria**

Responses;" and "Opposition's Response to Questions –Set One," submitted by the Nebraska Academy of Eye Physicians and Surgeons)

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

5) Alternatives to the proposal

5 A) Co-management and consultation

Some committee members indicated that one way to address potential new harm from expanded optometry practice and provide a benefit to the public would be for both parties to work together, and that working together should include 'co-management' of patient care. **(The Second Meeting of the Committee, held June 7, 2013)**

The committee members were informed that optometrists and ophthalmologists work well together, already. The applicants commented that they often consult with physicians about the details of specific cases. Applicant spokespersons clarified that co-management should not be defined to require that every change in treatment be checked or approved in advance by the other party. They said that they prefer the term 'consultation' to 'co-management' as the most appropriate term to use in this context because it is more consistent with independent practice. Comment was made that there are many levels of consultation. **(The Second Meeting of the Committee, held June 7, 2013)**

5 B) *Other alternatives*

Ophthalmology representatives stated that they would like to see the creation of an integrated eye care model on a national scale and noted that such a model of care would create a framework of cooperative care among all eye care professionals. **(The Second Meeting of the Committee, held June 7, 2013)**

Note: All sources listed in this section are located on the program website at http://dhhs.ne.gov/Pages/reg_admcr.aspx

Part Five: Recommendations of the Technical Committee

Committee Actions Taken on the Six Scope of Practice Criteria:

The committee members took action on each of the six statutory criteria by voting on whether the proposal satisfies each criterion or not. These committee actions were as follows:

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

Action taken: A majority of the committee members agreed that the proposal satisfies this criterion. Voting yes were Dering-Anderson, Wyrens, Sandstrom, McCarty, and Howorth. Peters voted no. Ms. Parsow did not vote.

Comments from the committee members were as follows:

Those committee members who voted to approve the proposal on this criterion commented as follows:

- Access to eye care services in remote rural areas of Nebraska is inadequate.
- The use of such things as EpiPens should be part of the optometry scope of practice so that optometrists can better deal with medical emergencies.
- The public needs optometrists to be able to provide more services.
- If optometry scope of practice is not expanded Nebraska could begin to lose optometry practitioners to other states that already have an expanded scope of practice. The current restrictions on the scope of practice in Nebraska will eventually have an adverse impact on the ability of the profession to recruit and retain members.

Those committee members who voted against approval of the proposal on this criterion commented as follows:

- Adding more practitioners to those who can provide a service increases risk of harm to the public.
- Information available from other states that have passed similar proposals indicates that access to services has not increased.

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Action taken: A majority of the committee members agreed that the proposal satisfies this criterion. Voting yes were Dering-Anderson, Wyrens, Sandstrom, McCarty, Peters, and Howorth. Ms. Parsow did not vote.

Comments from the committee members were as follows:

- There was a consensus that the proposal would increase access to certain eye care services currently unavailable in many remote areas of Nebraska.
- One committee member commented that the ability to utilize EpiPens would be a benefit in addressing some medical emergencies.

<u>Criterion three</u>: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Action taken: A majority of the committee members agreed that the proposal does not satisfy this criterion. Voting yes were Dering-Anderson, Wyrens, and McCarty. Voting no were Sandstrom, Peters, Howorth, and Parsow.

Comments from the committee members were as follows:

Those committee members who voted to approve the proposal on this criterion commented as follows:

- Optometrists are highly professional in their approach to patient care. This professionalism will go a long ways toward managing the shortcomings of the proposal and protecting the public from harm.
- Optometrists can be trusted to abide by standards of care and refer to other providers when necessary.

Those committee members who voted against approval of the proposal on this criterion commented as follows:

- There are too many gaps in optometry education and training, especially as regards the prescribing of powerful immunosuppressants and the administration of minor surgical procedures.
- Optometrists need more medical training in order to provide the proposed scope of practice safely and effectively.

<u>Criterion four</u>: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Action taken: A majority of the committee members agreed that the proposal does not satisfy this criterion. Voting yes were Dering-Anderson and McCarty. Voting no were Wyrens, Sandstrom, Peters, and Howorth. Ms. Parsow did not vote.

Comments from the committee members were as follows:

Those committee members who voted to approve the proposal on this criterion commented as follows:

- The current proposed education and training are adequate to protect the public from harm.
- The current proposed education and training will continue to progress.

Those committee members who voted against approval of the proposal on this criterion commented as follows:

- Too many important educational components necessary for making this proposal safe and effective are not provided for in the applicants' proposal. There is insufficient

education and training to manage surgical procedures or oral immunosuppressants, for example.
- Who is going to teach these new scope elements, and where is this teaching going to occur? The logistics of this aspect of the proposal eluded some committee members.
- Eliminating the surgical component would have made it easier to approve the proposal on this criterion.

<u>Criterion five</u>: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner.

Action taken: A majority of the committee members agreed that the proposal satisfies this criterion. Voting yes were Dering-Anderson, Wyrens, McCarty, and Howorth. Voting no were Sandstrom and Peters. Ms. Parsow did not vote.

Comments from the committee members were as follows:

Those committee members who voted to approve the proposal on this criterion commented as follows:
- Accessible post-professional programs already exist in optometry.
- These programs are adequate to assure competency.

Those committee members who voted against approval of the proposal on this criterion commented as follows:
- The post-professional programs that currently exist are not adequate to provide assurance of competency.
- These programs are too limited and lack rigor. There is a need for additional continuing education hours and 'refresher courses' should be required as well.

<u>Criterion six</u>: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Action taken: A majority of the committee members agreed that the proposal does not satisfy this criterion. Voting yes were Dering-Anderson, Wyrens, and McCarty. Voting no were Sandstrom, Peters, Howorth, and Parsow.

Comments from the committee members were as follows:

Those committee members who voted to approve the proposal on this criterion commented as follows:
- The Board of Optometry has the authority and ability to administer the proposal if it passes.
- Nebraska is a mandatory reporting state which greatly assists the Board in doing its job.

Those committee members who voted against approval of the proposal on this criterion commented as follows:

- The Board of Optometry would not be able to control which optometry practitioners provide these services.
- This Board of Optometry would not be able to measure the competency of each optometry provider.
- Many optometrists will refuse to use any of these new scope elements which raises questions of the value of this proposal.
- Regulations governing a similar proposal in Kentucky are too general. Testing is not adequate and the education and training has too many gaps in it. The Board of Optometry cannot compensate for all of the deficiencies of the proposal.

Committee Actions Taken on the Entire Proposal:

The committee members took action on the entire proposal after they completed their actions on the six statutory criteria.

Action taken: A majority of committee members recommended against approval of the proposal. Voting yes were Dering-Anderson, Wyrens, and McCarty. Voting no were Sandstrom, Peters, Howorth, and Parsow.

Comments from the committee members were as follows:

Those committee members who voted to approve the proposal commented as follows:

- Access to quality eye care services is a serious issue in underserved areas of Nebraska, and the proposal holds promise of addressing these needs.
- Optometrists are better located to meet the needs of patients in underserved areas than are ophthalmologists. Optometrists are more likely to be residents of communities in underserved areas than are ophthalmologists, for example.
- Yes, there are concerns about optometry education and training, but these concerns have been overstated by the opponents. Optometry education and training is adequate to provide the proposed new scope of practice safely and effectively.
- Evidence shows that optometrists behave in a professional manner. Consistent with this sense of professionalism, optometrists who do not feel comfortable providing the new scope elements won't provide these services. Those optometrists who do provide these new services can be trusted to consult or refer as needed to ensure patient protection. For these reasons there is no basis for the argument that approving this proposal would jeopardize public safety.
- No valid evidence was presented to indicate that optometrists have ever practiced in a manner that is unsafe.

Those committee members who voted against approval of the proposal commented as follows:

- The problems identified with the current practice situation by the applicants are not major health care problems.
- There was no convincing evidence that there is a need for this proposal by consumers of eye care services.
- There are too many gaps in optometry education and training, creating concerns about the safety of the proposal.

- The applicants did not demonstrate that they are able to manage the eye care problems of patients with complex health care issues or diseases safely and effectively.
- The applicants did not demonstrate that the elements in the proposal pertinent to prescribing powerful immunosuppressants or the elements of the proposal pertinent to minor surgical procedures are adequately supported by optometric education and training.
- The testing and assessment aspects of optometry education and training pertinent to the items being requested need more development and rigor.

Committee discussion revealed that there was agreement among the committee members that the following elements of the proposal would be beneficial to the public and could be incorporated into optometry scope of practice without jeopardizing public safety:

- Oral glaucoma medications
- Oral steroids
- The utilization of EpiPens, and some other injection procedures

Committee discussion revealed that there was agreement among a majority of committee members that the prescription of powerful immunosuppressants and the utilization of minor surgical procedures are not adequately supported by optometry education and training and should not be approved.

Ancillary Recommendations:

1) Dr. Dering-Anderson moved and Mr. Howorth seconded that a special committee be created consisting of physicians, pharmacists, and optometrists that would be granted authority to create a formulary for the purpose of defining which pharmaceutical agents optometrists would be allowed to use. This committee would be created by the Legislature and placed under the Board of Optometry. Voting yes were Dering-Anderson, Wyrens, Sandstrom, Peters, McCarty, Howorth. Ms. Parsow did not vote. The motion passed.

2) Dr. Sandstrom moved and Dr. Dering-Anderson seconded that a standard be defined for the utilization of surgical procedures by optometrists, and that this standard would require that optometrists who want to provide such services complete an accredited surgical residency program, or equivalent program, that would provide practical, hands-on training for optometrists on live patients. Voting yes were Dering-Anderson, Wyrens, Sandstrom, Peters, McCarty, and Howorth. Ms. Parsow did not vote. The motion passed.

3) Dr. Sandstrom moved and Mr. Peters seconded that an integrated approach be developed among eye care professionals pertinent to the utilization of immunosuppressants in which optometrists would be required to work with ophthalmologists to co-manage the use of such drugs when they are treating the eye care needs of patients who have either complex eye diseases, or who have other complex health conditions that complicate their eye care treatments. Voting yes were Wyrens, Sandstrom, Peters, and Howorth. Voting no were Dering-Anderson and McCarty. Ms. Parsow did not vote. The motion passed.